## Georgia Department of Human Services CHILD CARE APPLICATION and REFERRAL FOR CHILD IN DFCS CUSTODY

| A. CHILD INFORMATION (To be completed by Social Service Case Manager (SSCM) )  |       |  |      |                  |                                       |                       |                      |                           |                  |                |
|--|-------|--|------|------------------|---------------------------------------|-----------------------|----------------------|---------------------------|------------------|----------------|
| First Name   | MI    | Last Name  | Sex  | Date of<br>Birth | Social<br>Security<br>Number          | Child<br>in<br>School | Child<br>in<br>Pre-K | Child in<br>Head<br>Start | Child<br>Special | l has<br>Needs |
|  |       |  |      |                  |                                       | Y N                   | Y N                  | ΥN                        | Υ                | N              |
| Legal County (county that h  | U.S   | U.S. Citizen: ☐ Yes ☐ No Born in Georgia: ☐ Yes ☐ No |      |                  |                                       |                       |                      |                           |                  |                |
| Ethnicity (check one): ☐ Hispanic ☐ Not Hispanic   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| Race (check one): ☐ White ☐ Black/African American ☐ Asian   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| □ American Indian or Alaskan □ Native Hawaiian or other Pacific Islander   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| B. PLACEMENT INFORMATION (To be completed by SSCM) If two adult caretakers, provide information for both   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| Name(s):   |       | Address:   |      |                  |                                       | Home Ph               | one #                |                           |                  |                |
| □ DFCS Foster Parent   |       |  |      |                  | Work Phone #                          |                       |                      |                           |                  |                |
| ☐ CPA Foster Parent☐ Non-Foster Parent   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| Did you ask the responsible adult if they are not registered to vote where they live now, if they wanted to register to vote?  □ Yes □ No  |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| If an informal child care provider has been chosen, check all f ☐ Relative of Child ☐ Care provided in ch ☐ Care provided in |       |  |      |                  | nome   E                              | CRC cor<br>CPS scre   | eening co            | oves Infor                |                  |                |
| New placement or new provider changes MUST be reported to the child care case manager within 24 hours. All other changes must be reported within 5 working days.   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| Type of Action: ☐ New Application ☐ Renewal Application ☐ Placement Change ☐ Provider Change   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| Printed Name of SSCM Sign  |       |  |      | Signature        | ature of SSCM Date                    |                       |                      |                           |                  |                |
| C. CHILD CARE PROVIDE  | ER II | NFORMATION (T  | o be | completed        | by the SSCN                           | 1)                    |                      |                           |                  |                |
| Reason Care is Needed:   |       |  | Nam  | e, Address       | and Phone #                           | of Childcar           | e Provide            | er:                       |                  |                |
| Days and Hours Care is Needed:   |       |  | Dhor | ne # (           | ١                                     |                       |                      |                           |                  |                |
| Phone # (  |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| <ul> <li>D. ELIGIBILITY DETERMINATION (To be completed by the Child Care case manager)</li> <li>1. Date Form 57 received by CAPS</li> <li>5. Rate within DFCS Maximum? ☐ Yes ☐ No</li> </ul>   |       |  |      |                  |                                       |                       |                      |                           |                  |                |
| 2. Family Unit Size1_  |       |  |      |                  | Cost of care if not within maximum \$ |                       |                      |                           |                  |                |
| 3. UAS Code (check one): ☐ 555 (Pre-K) ☐ 557   |       |  |      | 6.               |                                       |                       |                      |                           |                  |                |
| <ul> <li>4. Provider is: ☐ Licensed, Commissioned, or Exempt</li> <li>☐ Registered-Family Home Daycare or Group Home</li> <li>☐ Informal- Relative of Child ☐ Informal- Non-Relative</li> </ul>  |       |  |      |                  | 7. Official Certification Period:to   |                       |                      |                           |                  |                |
| Comments:  |       |  |      |                  |                                       |                       |                      |                           |                  |                |
|  |       |  |      |                  |                                       |                       |                      |                           |                  |                |

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Date

CAPS Case ID #

Signature of CAPS Case Manager